CITY OF COUNCIL BLUFFS
209 PEARL STREET
COUNCIL BLUFFS IA 51503

Return completed form to Personnel Department
712-328-4604

Covered Person or Covered Person's Dependent
Authorization for Disclosure of
Personal Health Information

This authorization complies with the HIPAA Privacy Rule and permits health care providers and other covered entities to disclose personal health information

1. I initiate this authorization for disclosure of my personal health information (defined in #2). I authorize my Group Health Plan, its agents, and business associates to disclose my personal health information as described below:

   a) Please disclose my personal health information to (check as applicable):

   ☐ My employer/plan sponsor (Please include name and address of person or entity to whom the information described below is to be disclosed):

   Employer: _____

   Attn: _____

   Address: _____

   _____

   ☐ Another person or entity (Please include name and address of person or entity to whom the information is to be disclosed):

   Name: _____

   Address: _____

   _____

   b) Describe the personal health information to be disclosed (check as applicable):

   ☐ Please disclose any and all personal health information requested by the person or entity described above.

   ☐ Please disclose my personal health information necessary for the person or entity described above to act as a claim advocate:

   _____

   ☐ Other (please describe):

   _____

   c) Reason for the disclosure (optional):

   _____

2. I understand my personal health information may be used or disclosed as set forth by this authorization. Protected health information includes information created or received by my Group Health Plan and its agents and business associates. Protected health information also includes but is not limited to: hospital records, treatment records/notes, alcohol or drug abuse treatment, consultation reports, workers' compensation information, diagnosis, prescriptions, test results, vocational testing/counseling information, and benefit information.

3. If you are the representative of the covered person or the covered person's dependent (including a covered person acting as a representative on a covered dependent's behalf) describe the scope of your authority to act on the covered person's or covered dependent's behalf:

---

4. I understand that any information disclosed under this authorization may no longer be covered by the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and may be subject to redisclosure. I understand that any personal health information received by my employer under this authorization will be kept strictly confidential and will be segregated from records relating to my employment. It will be used solely for the purpose for which the disclosure was authorized.

5. I understand that I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization, if the request for revocation is in writing and sent to the City of Council Bluffs Personnel Office, 209 Pearl, Council Bluffs, IA 51503. The City will then forward a copy of any requests you receive to revoke an authorization that pertains to coverages administered by Principal Life Insurance Company to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, 711 High, Des Moines, IA. 50392-0002]. To request a revocation form, contact the Health Information Protection Analyst at the address listed previously. I also understand that the exception to this revocation is to the extent that action has been taken in reliance on this authorization. Such revocation shall not apply to any use or disclosure of my Protected Health Information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses and disclosures that HIPAA allows without my authorization.

6. This authorization will be valid (check as applicable):

   ☐ For the term of the medical, dental, and/or vision coverages I am enrolled in and any renewal of those coverages unless state or federal law requires a shorter expiration period.

   ☐ For as long as necessary to bring the specific claim or situation described above to a conclusion.

7. I understand that I am not required to sign this authorization form and that my Group Health Plan will not condition the provision of payment of a claim for medical, dental, and/or vision coverages [insert other applicable HIPAA coverages, if appropriate] on the signing of this authorization.

ACKNOWLEDGEMENT

I initiate this authorization for disclosure of personal health information. I have read and I understand this authorization. Upon receipt of your signed authorization, a copy will be provided to you. A photocopy of this authorization shall be considered as effective and valid as the original. No alteration of this form will be accepted. By my signature, I acknowledge that any prior agreements I have made to restrict my personal health information do not apply to the information released under this authorization.

Covered person/covered dependent name (please print) **Date of Birth** **I.D. Number**

Covered person/covered dependent address **Phone Number**

City of Council Bluffs *N-32915*

Employer Name **Account Number**

209 Pearl Street, Council Bluffs IA 51503

Employer Address

Name of personal or legal representative (if applicable)

Relationship of personal or legal representative to covered person or covered dependent.
If signing on behalf of another, include proper documentation that attests to your ability to sign (Death Certificate, court-stamped Letters of Appointment of the Executor of Estate, proof of custody, power of attorney, etc.).

X

Signature of covered person/covered dependent (or covered person's/covered dependent's representative) **Date**